AMENDED IN ASSEMBLY APRIL 10, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 2252

Introduced by Assembly Member Gordon

February 24, 2012

An act to amend Section 1375.7 of the Health and Safety Code, and to amend Section 10133.65 of the Insurance Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 2252, as amended, Gordon. Dental coverage: provider notice of changes.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Under the Knox-Keene Act, the Health Care Providers' Bill of Rights prohibits a contract between a health care service plan and a health care provider from including a term authorizing the plan to change a material term of the contract unless the parties have agreed to it or it is required to comply with state or federal law or with accreditation requirements of a private sector accreditation organization. Under existing law, if a change is made by amending a manual, policy, or procedure document referenced in the contract between a plan and a provider, the plan is required to provide at least 45 business days' notice to the provider, as specified.

This bill would require a plan providing dental coverage to also provide at least 45 business days' notice to dentists providing services under its plan contracts of any change to the plan's rules, regulations, guidelines, policies, or procedures concerning dental provider

contracting or coverage of or payment for dental services, as specified. The bill would give the dentist the right to negotiate and agree to the change and to terminate its contract with the plan if an agreement cannot be reached. *The bill would also require a plan providing dental coverage that automatically renews dental provider contracts to, at least 45 business days prior to a contract renewal date, provide to the provider a summary of all the changes made, as specified, since the contract was issued or last renewed, whichever is later. The bill would allow the provider to terminate the contract within 30 business days of receiving the summary.* Because a willful violation of these provisions would be a crime, the bill would impose a state-mandated local program.

Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health insurers to contract with providers for alternative rates of payment and authorizes the contract to contain provisions permitting a material change to the contract if the insurer provides at least 45 business' days notice to the provider and the provider has the right to terminate the contract prior to implementation of the change.

This bill would require an insurer providing dental coverage to also provide at least 45 business days' notice to dentists providing services under its health insurance policies of any change to the insurer's rules, regulations, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, as specified. The bill would give the dentist the right to terminate its contract with the insurer prior to implementation of the change. *The bill would also require an insurer providing dental coverage that automatically renews dental provider contracts to, at least 45 business days prior to a contract renewal date, provide to the provider a summary of all the changes made, as specified, since the contract was issued or last renewed, whichever is later. The bill would allow the provider to terminate the contract within 30 business days of receiving the summary.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1375.7 of the Health and Safety Code is amended to read:

1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:

(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.

(C) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the

Medi-Cal or Healthy Families program and compensates the provider on a fee-for-service basis, the contract may contain provisions permitting a material change to the contract by the plan, if the following requirements are met:

(i) The plan gives the provider a minimum of 90 business days' notice of its intent to change a material term of the contract.

(ii) The plan clearly gives the provider the right to exercise his or her intent to negotiate and agree to the change within 30 business days of the provider's receipt of the notice described in clause (i).

(iii) The plan clearly gives the provider the right to terminate the contract within 90 business days from the date of the provider's receipt of the notice described in clause (i) if the provider does not exercise the right to negotiate the change or no agreement is reached, as described in clause (ii).

(iv) The material change becomes effective 90 business days from the date of the notice described in clause (i) if the provider does not exercise his or her right to negotiate the change, as described in clause (ii), or to terminate the contract, as described in clause (iii).

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional

liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) With respect to a health care service plan contract covering dental services or a specialized health care service plan contract covering dental services, ~~if~~ *all of the following shall apply:*

(1) If a change is made to the health care service plan's rules, regulations, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, the plan shall provide at least 45 business days' written notice to the dentists providing services under the plan's individual or group plan contracts, including specialized health care service plan contracts, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. Each dentist has the right to negotiate and agree to the change. If the plan and a dentist cannot agree to the change, the dentist has the right to terminate its contract with the plan prior to the implementation of the change. If the parties mutually agree, the 45-business-day notice requirement may be waived. Nothing in this ~~subdivision~~ *paragraph* limits the ability of the parties to mutually agree to the proposed change at any time after the dentist has received notice of the proposed change. This ~~subdivision~~ *paragraph* shall apply in addition to the other applicable requirements imposed under this section, except that it shall not apply where notice of the proposed change is required to be provided pursuant to subparagraph (C) of paragraph (1) of subdivision (b).

(2) For purposes of paragraph (1), a change made to a health care service plan's rules, regulations, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services includes, but is not limited to, a change to the system by which the plan adjudicates and pays claims for treatment, a change to the manner in which the plan identifies patients and providers, a change to the fee and rate schedule for the product for which the dentist is in-network, a change to the coverage or general policies of the plan that affect rates and fees

paid to providers, and a change to enrollees' benefit coverage policies.

(3) A plan that automatically renews a contract with a dental provider shall, at least 45 business days prior to the contract renewal date, provide to the provider a summary of the changes described in this subdivision and paragraph (1) of subdivision (b) that have been made since the contract was issued or last renewed, whichever is later. The provider shall have the right to terminate the contract within 30 business days of receiving the summary. If the provider does not notify the plan of its desire to terminate the contract within that 30-business-day period, the contract shall be automatically renewed.

(d) (1) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(2) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 1395.6.

(B) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 1395.6.

(e) Any contract provision that violates subdivision (b), (c), or (d) shall be void, unlawful, and unenforceable.

(f) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 into a report and submit the report to the Governor and the Legislature by March 15 of each calendar year.

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

(h) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

SEC. 2. Section 10133.65 of the Insurance Code is amended to read:

10133.65. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a health insurer and a health care provider for the provision of covered benefits at alternative rates of payment to an insured shall contain any of the following terms:

(1) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(2) A requirement to comply with quality improvement or utilization management programs or procedures of a health insurer, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the health insurer may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to subdivision (c).

(3) A provision that waives or conflicts with any provision of the Insurance Code.

(4) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) If a contract is with a health insurer that negotiates and arranges for alternative rates of payment with the provider to provide benefits to insureds, the contract may contain provisions permitting a material change to the contract by the health insurer if the health insurer provides at least 45 business days' notice to the provider of the change, and the provider has the right to terminate the contract prior to implementation of the change.

(d) With respect to a health insurance policy covering dental services or a specialized health insurance policy covering dental services, ~~if~~ *all of the following shall apply:*

(1) If a change is made to the health insurer's rules, regulations, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, the insurer shall provide at least 45 business days' written notice to the dentists providing services under the insurer's individual or group health insurance policies, including specialized health insurance policies. Each dentist shall have the right to terminate its contract with the insurer prior to the implementation of the change. This ~~subdivision~~ *paragraph* shall apply in addition to the other applicable requirements imposed under this section.

(2) For purposes of paragraph (1), a change made to a health insurer's rules, regulations, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services includes, but is not limited to, a change to the system by which the insurer adjudicates and pays claims for treatment, a change to the manner in which the insurer identifies patients and providers, a change to the fee and rate schedule for the product for which the dentist is in-network, a change to the coverage or general policies of the insurer that affect rates and fees paid to providers, and a change to insureds' benefit coverage policies.

(3) An insurer that automatically renews a contract with a dental provider shall, at least 45 business days prior to the contract renewal date, provide to the provider a summary of the changes described in paragraph (1) and subdivision (c) that have been made since the contract was issued or last renewed, whichever is later. The provider shall have the right to terminate the contract within 30 business days of receiving the summary. If the provider does not notify the insurer of its desire to terminate the contract within that 30-business-day period, the contract shall be automatically renewed.

(e) Any contract provision that violates subdivision (b), (c), or (d) shall be void, unlawful, and unenforceable.

(f) The Department of Insurance shall annually compile all provider complaints that it receives under this section, and shall report to the Legislature and the Governor the number and nature of those complaints by March 15 of each calendar year.

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between health insurers and health care providers.

(h) For purposes of this section, the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(2) "Health insurer" means any admitted insurer writing health insurance, as defined in Section 106, that enters into a contract with a provider to provide covered benefits at alternative rates of payment.

(3) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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